Strategy	Three-Share/Multi-Share Programs
Background:	During the past several years, a number of states and local communities have developed programs to provide health-care coverage to uninsured employees of small businesses using a blend of employer, employee and public funds. Often, small employers cannot afford to provide commercial health insurance to their employees, and lower wage employees cannot afford the employee contribution. The goal of these programs is to offer benefits packages that are attractive and affordable to both small employers and employees. Some of the programs that have been developed and coordinated at the community level have been termed "three-share" programs because typically the employer, employee, and public entity each pay for one third of the premium. They also are referred to as "multi-share" programs because the public share of the premium may be financed by more than one level of government, and private donations or other private funds also may contribute to the program. It is important to note that while these programs provide increased healthcare **coverage**, they do not necessarily provide what most people think of as health **insurance.** Differences may include a more limited benefits package and a closed, local provider network. If someone in a three-share program seeks medical care outside of the local area, this care may not be covered at all. Three-share approaches have been used in other states — including New Mexico, Oklahoma, and Arkansas — have received Medicaid Health Insurance Flexibility and Accountability (HIFA) waivers to expand coverage to the working uninsured statewide. While their programs are not called three-share programs, they blend funding from the employer, employee and public source(s) to provide coverage to the working uninsured. This paper will focus on community-based three-share programs but also will provide a high level overview of some of the coverage offered statewide under HIFA waivers. <u>Typical characteristics of three-share/multi-share programs</u> • More affordable benefits package than average commercial insurance. Three-share programs have an average premium cost of $150-$180 per participant per month. Benefits include primary care, specialty care, drugs, and limited inpatient services. For comparison, Texas Employee Retirement System health insurance has a premium cost of $270-$360 per active state employee per month. Small employers pay more than this for comparable coverage because they don't have such a large number of covered people (which spreads the risk). • Limited to small employers (fewer than 25 or 50 employees). • Often targeted to employers with relatively low median wages (under $15 per hour).

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	• Benefits and eligibility determined at the local level. • A non-profit may be established to finance and oversee the program, services provided via a contract with a health maintenance organization (HMO) or third party administrator. • The public share may include federal matching funds by drawing down a federal match. Lessons learned • Community assessment and involvement is critical to designing a successful program. • Existing programs have minimal up-front employee cost sharing (e.g. deductibles) because this type of cost sharing may discourage the targeted employee population from joining the program. Instead, employees pay nominal co-pays for services received. Texas Initiatives Texas submitted a Children's Health Insurance Program (CHIP) HIFA waiver in December 2005 for a three-share program in Galveston County. Other Texas communities also are considering three-share programs as a way to increase healthcare coverage in their communities. HHSC anticipates more questions from the Centers for Medicare and Medicaid Services (CMS) on the Galveston proposal, and CMS has indicated that federal approval is more likely for a statewide approach rather than individual, locally based waivers. One possibility would be for the waiver to include an option for other communities across the state to participate. • The Galveston waiver proposal would cover 2,710 working parents of Medicaid and CHIP children under 200 percent of the federal poverty level (FPL). • Houston/Harris County has proposed a program that would cover 100,000 working uninsured individuals (10 percent of the area's uninsured) with annual incomes below $50,000. • A group of Dallas hospitals has proposed a non-insurance, indemnity three-share program to cover up to 35,000 uninsured employees of small business. Inpatient services would not be covered. • El Paso and Austin also are exploring coverage options for uninsured employees of small businesses. While federal waivers are an established mechanism to incorporate federal funds into three-share programs, some Texas communities are exploring ways to implement these programs without a federal waiver or any Medicaid or other

Strategy	Three-Share/Multi-Share Programs
	federal funds.
Other States:	Community-Based Three-Share/Multi-Share Programs Michigan has four counties with three-share programs in operation, and Illinois has three such community programs. **Michigan** has had three-share programs for a number of years and has served as a model for other states. As of December 2004, Wayne County's initial three-share program (Health Choice) had 4,310 participants, and as of December 2006, Muskegon County's program had served over 3,500 individuals from 526 small businesses. In Michigan, the public share is financed through a special financing arrangement in which counties send IGTs to the state, the state pays Disproportionate Share Hospital (DSH) funds to hospitals, and the hospitals contribute DSH funds to the nonprofit organization in each county that administers the three-share program. Wayne County also has a new three-share program, the Four Star Health Program, which will be administered by health systems in collaboration with the county rather than being administered by the county. With both of its three-share programs, the goal is to cover between 10,000-15,000 residents, or about 5 percent of Wayne County's 250,000 uninsured. In **Illinois**, counties/cities that have three-share programs certify Medicaid loss for local health departments (which are paid less than cost), and the resulting additional federal funds are used to finance the program. Florida, West Virginia, and Ohio also have worked to develop community-based three-share programs. Statewide Three-Share "Like" Coverage Initiatives A number of states have received federal approval for HIFA waivers that include three-share approaches. **New Mexico** – New Mexico State Coverage Insurance program implemented July 2005. As of June 2006, there are approximately 4,700 enrollees. Working adults up to 200 percent FPL in businesses with less than 50 or fewer employees may participate. Employer pays $75 per member per month, the employee pays $0-$35 per member per month, and public funds pay premium balance. New Mexico estimates 174,000 uninsured could qualify for the program, and estimates 8,500 enrollees by the end of the second year and 40,000 enrollees within five years. **Oklahoma** – Implemented November 30, 2005. Program covers those up to 185 percent FPL in businesses with 50 or fewer workers, proposes to cover 50,000 residents. As of June 2006, 440 employers and 803 employees/spouses have enrolled. Employer pays at least 25 percent of premium; employee pays the lesser of 15 percent of the premium or 3 percent of their gross income. State pays balance

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<tr><td>Strategy</td><td>Three-Share/Multi-Share Programs</td></tr>
<tr><td></td><td>of premium.

Other states have recently had public-private coverage expansions approved, including Arkansas, California, and Massachusetts.</td></tr>
<tr><td>Application to Texas –

Advantages & Disadvantages:</td><td><u>Advantages</u>:
• Due to Texas' high uninsured rate among the working population, Texas has a sizeable population that could benefit from multi-share programs.
• Involving local community stakeholders in program and benefit design helps ensure that each program is tailored to the employers and employees in that community and offers a benefit package they would be willing to purchase.
• Texas may be able to add a three-share component to other state programs, such as the proposed CHIP Premium Assistance program, to enable more families to participate in these programs by contributing to the monthly premium.
<u>Disadvantages</u>:
• Established three-share programs have target uptake rates of between 5 and 10 percent of the target population. These target uptake rates are higher than those for premium assistance programs for the existing Medicaid and CHIP populations (HIPP and CHIP Premium Assistance) because fewer existing recipients have jobs with cost-effective employer-sponsored coverage. At these uptake rates, three-share programs likely would cover a small percent of Texas' uninsured. They could, however, be one component of a coordinated approach to increase healthcare coverage.
• Three-share programs have more limited benefits than traditional Medicaid and many commercial insurance plans so they would only provide partial coverage for those with chronic health conditions or high acute care costs.</td></tr>
<tr><td>Meets Medicaid Reform Goal(s):</td><td>
<table>
<tr><td>Cost Reduction or Avoidance</td><td>X</td><td>Maximizes federal funds</td><td>X</td><td>Improves Program Sustainability</td><td></td><td>Consumer Choice/ Responsibility</td><td></td></tr>
<tr><td>Reduces Number of Uninsured</td><td>X</td><td>Supports Private Market Coverage</td><td>X</td><td>Improves Quality</td><td></td><td>Improves Access</td><td></td></tr>
<tr><td>Benefit Options</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<tr><td>Populations Affected:</td><td>Over 2.3 million employed Texans ages 18 to 64 (over 25 percent) lack health insurance. Almost half of these individuals work in companies with fewer than 25 employees.[i] Three-share programs often target those in this group with incomes below 200 percent FPL, but could cover some employees in the other income brackets as well. The Texas counties with the highest number of uninsured residents are Harris, Dallas, Bexar, Tarrant, El Paso, Hidalgo, and Travis.[ii]</td></tr>
<tr><td>General Revenue Impact:</td><td>Impact would depend on how Texas finances three-share programs. If local and federal monies are used to fund the public share of the program, then there would</td></tr>
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<tr><td>Strategy</td><td colspan="6">Three-Share/Multi-Share Programs</td></tr>
<tr><td></td><td colspan="6">be no GR impact. If GR is used as the state match for the public share, then it would cost approximately $20-$30 in GR per member per month for the program. If the program grew to 100,000 participants per year, the GR cost would be estimated at $24 million to $36 million per year.

There also would be administrative costs for the program, which would vary depending on the role that the state and local communities play in the program.</td></tr>
<tr><td rowspan="2">Other Considerations</td><td colspan="2">Stand Alone Option</td><td></td><td colspan="2">This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
<tr><td colspan="6">There are many similarities between locally based three-share programs and statewide coverage programs implemented through a Medicaid HIFA waiver (New Mexico, Oklahoma, and Arkansas) or low-income pool (Massachusetts and California). Both are strategies to expand health-care coverage to low-income individuals using a combination of public, employer, and individual funds.

The fundamental difference between locally based programs and statewide initiatives is the source of public funding and the administration of the program. Locally based programs are developed and administered at the local level and use local funds to pay for a portion of the coverage. Typically they limit coverage to a closed, local network of providers. Another difference between locally based three-share programs and statewide coverage initiatives is that three-share programs inherently focus on covering the working uninsured, whereas statewide coverage initiatives may seek to cover both the working and non-working uninsured.

If Texas negotiates a low-income pool with the federal government and decides to use funds from the pool to increase coverage, it could do so either through a statewide program like Massachusetts or by allowing local communities to develop and implement programs using funds from the low-income pool as California does. A statewide approach would enable Texans throughout the state to participate in the program, whereas a local approach would allow local communities to develop programs that best meet their community needs. Also, Texas might be able to use a health insurance exchange like Massachusetts's Connector to facilitate participation in either type of coverage initiative.</td></tr>
<tr><td>State and Federal Approval(s) Required:</td><td rowspan="3">Federal</td><td>1115 Waiver</td><td>X</td><td rowspan="3">State</td><td>Rules</td><td>?</td></tr>
<tr><td></td><td>Other Waiver(s), [LIST]</td><td></td><td>Legislation</td><td>?</td></tr>
<tr><td></td><td>State Plan Amendment</td><td></td><td></td><td></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="6"><u>Affected Stakeholders</u>
• Small businesses and their employees.
• Health systems and providers in local communities that develop three-share</td></tr>
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Strategy	Three-Share/Multi-Share Programs

	programs. One goal of three-share programs is to reduce uncompensated care, which often is sought at safety net hospitals.
	
	Systems and Resource Considerations
	
	• Depends on roles of local communities and state.
	
	Implementation Timeframes (in months)
	
	• At least 18 months to:
	  o Determine eligibility, benefit design, scope of benefits, cost sharing, pricing.
	  o Request bids, select insurer, negotiate contract.
	  o Determine financing source and mechanism; secure financing.
	  o Implement administrative functions.
	  o Implement health plan.
	• If seeking a federal waiver, timeline also would be dependent on federal waiver approval. HHSC submitted the Galveston three-share waiver proposal in December 2005 and has not received federal approval as of January 2007.

[i] U.S. Census Bureau, March 2005 and March 2006 Current Population Surveys for Texas, Compiled by the Texas Demography Unit, Strategic Decision Support Department, Texas Health and Human Services Commission, January 2007. The 2.3 million figure is HHSC's estimate of working, uninsured U.S. citizens and legal permanent residents in Texas ages 18 to 64.
[ii] Texas Health and Human Services Commission, 2000.